Indicators of Well-Being Report:

Shasta County Children Prenatal to Five and Their Families

Prepared for

First 5 Shasta
the
Shasta Children and Families First Commission

By the

Indicators of Well-Being Project Team

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Acknowledgments

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Project Overview

Introduction
Proposition 10, enacted by legislation in 1998, supports First 5 Shasta, the *Shasta Children and Families First Commission* through a tax on the sale of tobacco products. These revenues are strictly designated to support new or expanded programs/activities aimed at enhancing the well-being of children in the prenatal stage to age 5.

The goals of First 5 Shasta are to:

1. Promote community understanding and valuation of early childhood development and child learning.
1. Increase services and resource accessibility.
1. Provide a safe environment for families and children to live in and to make sure that children are physically, mentally, emotionally, socially, and spiritually healthy, as well as receiving preparation for school.

As strategies and programs are implemented in Shasta County to assure healthy outcomes, an integral part of assessing their effectiveness is to take annual or biannual measurements of key indicators related to these goals. Development of a baseline from which to study trends and changes is the first step toward understanding how well children and families are performing. The report details 21 health and quality-of-life indicators that are crucial in gaining an understanding of how families and young children are managing in Shasta County. This report is envisioned as the first in a series of periodic reports tracking these indicators.

Purpose and Use of this Document
The study was collaboratively planned and conducted by a team specifically created for this purpose. The team was led by Muffy Berryhill, First 5 Shasta Executive Director and consisted of staff from three groups: current First 5 Shasta evaluators Duerr Evaluation Resources and Evaluation Solutions, with the added major assistance of the California State University, Chico's Center for Economic Development (CED).

In addition to serving as a baseline for First 5 Shasta activities, this document should prove useful to community groups and organizations. Data from this document may be used in better understanding the context in which children live and grow in Shasta County, in helping programs or organizations assess some of the needs of children in communities, in targeting areas for future research or data collection, and in strengthening grant applications for projects focusing on the county's young children

Reading this Document
The index to this report is intended to help readers locate the data or indicators, which are of most interest to them. Each page of the report is dedicated to one topic, with a general summary at the top and tables and/or graphs of the data below. The source and title of the graphical presentations of data will provide additional information about the population to which the data refers and any caveats that should be used in interpreting or generalizing from the data. Moreover, it should be remembered that it is rare that one indicator alone provides a valid illustration of a subject of interest. Therefore, where data is available, we have provided more than one related indicator or proxy indicators in order to enhance the understanding of the assets and needs experienced by children in the communities.

Each indicator is presented in the following narrative format:

- What the indicator means.
- Why the indicator is important.
- How children and families in Shasta County are doing.
- A detailed table and a chart accompanying the narrative, space permitting.
- Appendices and a glossary of words or phrases that are bolded and italicized in the narrative are attached to the report for reader clarification of key terms and to present supplemental data that does not fit on the indicator page for the indicator.
- In addition, please find attached to the report a detailed table with data sources for county and state indicators.

Project Methodology

The indicators examined in this report are based on those primarily identified in the First 5 Shasta *Strategic Plan*. An attempt was made to locate data related to the indicators through a variety of sources, including reference documents, government and public agency internet sites, and direct contact with individuals. The team made up to ten attempts via phone calls or electronic mail to obtain data. If after ten attempts it was determined that other options were viable, those leads were followed. Only after these extensive efforts were exhausted was work on the collection of data for a particular indicator halted.

The Team sought to collect data for the three most recent consecutive years. In some instances, however, a three-year span was not available. Data was always sought for both Shasta County and California, when available, for an analysis on how children and families are doing compared to the state average.

Lessons

One of the lessons of this experience has been the relative scarcity of data focusing on the well-being of children 0 to 5. In some cases, only state data was available for indicators of interest to the commission; in other cases, data could not be disaggregated by age of child. There is no data collection at all on some indicators of children's well-being, and in other cases, data is collected and stored manually, making it extremely labor intensive to retrieve. Also the quality or reliability of data collection procedures varies greatly and that confidence in the data varies correspondingly. Compiling this compendium of data has underscored the need to ensure that high quality data, collected in a reliable manner for a greater number of indicators, is available to inform programs and, eventually, priorities as a community with respect to children 0 to 5 and their families.

Final Words

It should be noted that, while this and other First 5 Shasta reports serve to provide baseline data, trends in the indicators selected over time will not tell the entire story of the successes and challenges of First 5 Shasta efforts. Similarly, because many such indicators will require years of efforts to change, and because Proposition 10 efforts do not occur in a vacuum, trends will be influenced by a number of factors in addition to state and local Proposition 10-related efforts. Strong evaluations of local efforts as well as attention to the potential effect of other factors (e.g., economic trends, demographic shifts, and newsworthy events) will contribute to the interpretation of potential causal connections.

Number of children ages 0 through 5 and pregnant women enrolled in Medi-Cal

*What does **Medi-Cal** enrollment mean?*
Medi-Cal can provide access to health care services for people whose assets and income are insufficient to pay medical bills and/or meet basic monthly needs. Those enrolled receive free or reduced-cost health care. The following are eligibility thresholds for pregnant women and families wishing to enroll in Medi-Cal:

- Pregnant women with incomes ≤ 200% of Federal Poverty Level (FPL),
- Children ages 1-5 with family incomes ≤ 133% FPL, and
- Children ages 6-19 and parents in families with incomes ≤ 100% FPL.

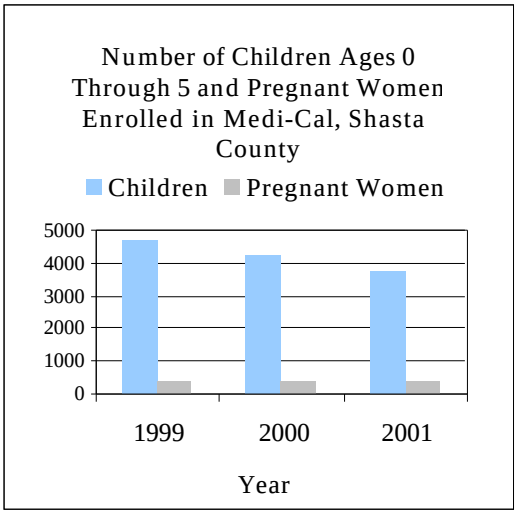
Why is it important?
For 25.3% of the children less than six-years of age in the U.S. in 1996, the only means of health coverage came from public insurance. Similarly, in 1996, the percentage of all persons in the U.S. with public health insurance as their only means of health coverage, including pregnant women, was 20.9%.[1]

How are we doing?
- In Shasta County, between the years of 1999 and 2001, the total number of children age 0 through 5 enrolled in Medi-Cal fell 17% to 3,729. The number of children in both age groups, less than 1 year and years 1 through 5, fell while the number of pregnant women remained about the same.
- In California, the total number of children age 0 through 5 enrolled in Medi-Cal fell 28% to 655,610 while the number of pregnant women rose 10% to 64,203.
- For a detailed yearly breakdown on children ages 0 to 4 eligible for Medi-Cal in Shasta County, please see Appendix A.

Number of Eligible Children 0 Through 5 and Pregnant Women Enrolled in Medi-Cal

	1999		2000		2001	
	Shasta	California	Shasta	California	Shasta	California
Children <1 Year	846	172,221	733	138,466	661	125,734
Children 1-5 Years	3,856	737,202	3,471	592,052	3,068	529,876
Pregnant Women	407	58,458	374	68,520	410	64,203

Source: California Department of Health Services, Medi-Cal Beneficiary Counts Pivot Table, January 1999 through April 2001.



[1] Weinick, R.M.& Weigers, M.E., Children's Health Insurance, Access To Care, And Health Status: New Findings, 1998.

Percentage of persons eligible for but not enrolled in Medi-Cal

*What does **Medi-Cal** eligibility mean?*
The Medi-Cal Program provides access to health care services for people whose assets and income are insufficient to pay medical bills and/or meet basic monthly needs.
Medi-Cal is a state-funded health insurance program for people who are low-income, elderly, disabled, or enrolled in TANF (Temporary Assistance to Needy Families). See Appendix A for eligibility details.

Why is it important?
The likelihood of a child being covered by private insurance has decreased in the last two decades.[2] Thus, public programs like Medi-Cal have become critical for the health and well being of children in lower income families.

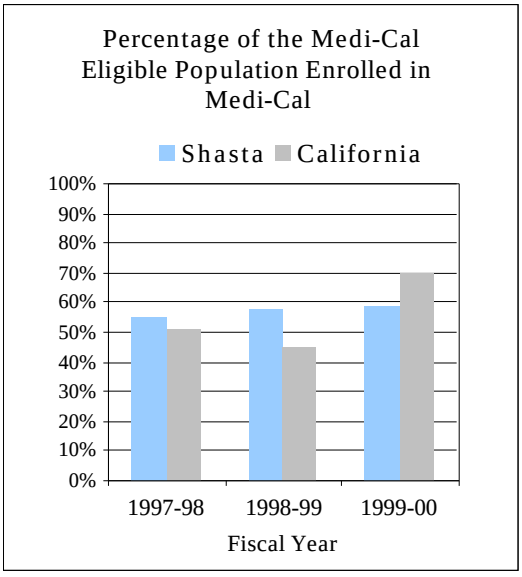
How are we doing?

- Both Shasta County and California showed decreases in the average annual number of eligibles between 1997 and 2000 with 11.3% and 14.1% respectively.
- Medi-Cal users as a percentage of eligibles increased throughout the three-year period for both Shasta County and California. However, they increased at exceedingly different rates. Over the period, the percentage increased 3.8% in Shasta County and 19.0% in California.

Medi-Cal Program Average Annual Eligibles, Enrollees, and Percentage of Eligibles Enrolled

	Shasta County			California		
Fiscal Year	Average Annual Eligibles	Average Annual Users	Percent of Eligibles Whom Are Enrolled	Average Annual Eligibles	Average Annual Users	Percent of Eligibles Whom Are Enrolled
1997-98	35,486	19,494	54.9%	3,780,279	1,929,060	51.0%
1998-99	33,460	19,387	57.9%	3,780,279	1,688,707	44.7%
1999-00	31,449	18,465	58.7%	2,366,490	1,656,318	70.0%

Source: State of California, Department of Health Services, Month of Payment Index Files, Fiscal Year 1997-98, Cumulative Certified CID Eligibles, and HCP Status Code 1 Reports.
Notes: County Organized Healthy Systems (COHS) counties are not included in this table due to incomplete data. Excludes Managed Care Plans.
Data for Sacramento County is incomplete.
Most Aid to Families with Dependent Children (AFDC) eligibles are covered by Geographic Managed Care (GMC).
Includes regular fee-for-service.
Averages are rounded independently and may not add to totals.
Age sensitive data not available.



[2] Weinick, R.M.& Weigers, M.E., Children's Health Insurance, Access To Care, And Health Status: New Findings, 1998.

Percentage of early care and education facilities that offer care for children in families with nontraditional work hours

What does early care during nontraditional hours mean?
Non-traditional hours in this study apply to the child care facilities that provide services outside the regular hours of 8 a.m. to 5 p.m. and on weekends.

Why is it important?
There has been a high and increasing demand for child care outside the realm of normal working hours. Welfare reform has resulted in many parents reentering the workforce where job availability is predicated on the acceptance of employment in the hours of the early mornings, nights, and weekends.[3] Similarly, there has been a shift towards a service based economy, jobs traditionally held by women, where businesses operates up to 24 hours a day.[4]

How are we doing?

- In 1997 and 1999, both Shasta County and California licensed and licensed-exempt ***child care centers*** offer little to no availability of child care outside the normal working hours of 8 a.m. to 5 p.m.
- ***Family child care homes*** in Shasta County and California offer a much higher availability of child care during nontraditional hours than do their licensed and ***licensed-exempt*** counterparts.
- Combined 1997 and 1999 averages indicate that approximately 38% of Shasta County family child care homes and 31% of California family child care homes offered care for children during nontraditional work hours.

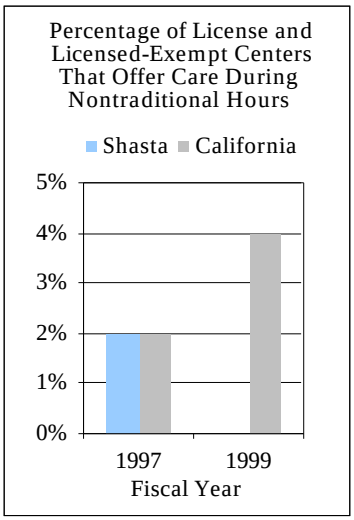
Percentage of Child Care Facilities That Offer Care During Nontraditional Hours

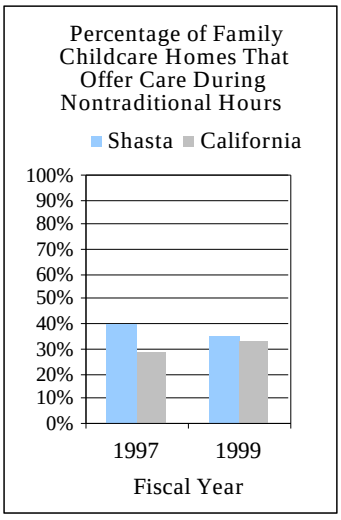
Year	Licensed and Licensed-Exempt Centers		Family Child Care Homes	
	Shasta	California	Shasta	California
1997	2%	2%	40%	29%
1999	0%	4%	35%	33%

Source: The California Child Care Portfolio 1997 & 1999.

Notes: Licensing is aimed to address the health and safety of the children in care. If an adult cares for children from only one family (in addition to his or her own), that individual is not required to have a license and considered to be license exempt.

There are five exemptions from licensing. A facility is licensed-exempt if a child is cared for by relatives related by blood, marriage, or adoption; has parents on site (health club, PEN Family Center, stores like Fred Meyer, etc.); is on a school site and/or involved in recreation program that lasts beyond one week; is placed into a co-op child care with another family and no money exchanges hands; or is cared for by a facility that is a provider for the children of only one.





[3] California Child Care Resource & Referral Network, The California Child Care Portfolio, 1997.
[4] Child Care Today, Care Around the Clock: Developing Child Care Resource before 9 and after 5, 1995.

Number of providers of early care and education services who will care for mildly ill children

What does child care for mildly ill children mean?
The California Department of Social Services keeps a record of child care facilities that provide services for children who are unable to go to their regular child care provider due to illnesses (i.e., colds, flu). Most child care facilities will not provide services for such children because of the risk of spreading disease or infection.

Why is it important?
Although the child's illness does not necessarily cause serious threat to other children, sick children do need special care in terms of food, a special regime, and isolation from other children if the child is contagious.[5] Facilities that care for mildly ill children also offer another outlet of care for parents/caregivers who may not be able to take time off of work or school to tend to their child.

How are we doing?

- In California, 9 licensed facilities that offer care to mildly ill children in California were operating in 1999 and 2000, and 8 were operating in 2001. None of these were in Shasta County.
- The total capacity of the child care facilities in California for mildly ill children declined slightly from 74 children in 1999 to 70 children in 2001. This represents less than 0.1% of total capacity statewide.

Licensed Child Care Facilities for Mildly Ill Children

Year	Shasta County		California	
	Total Capacity	Total Licensed Facilities	Total Capacity	Total Licensed Facilities
1999	0	0	74	9
2000	0	0	76	9
2001	0	0	70	8

Source: California Department of Social Services, Health and Human Services Agency.

Note: Data for the years 1999 and 2000 as of September 1; data for the year 2001 as of March 1.

[5] California Department of Developmental Services.

Number of domestic violence calls for Shasta County and California

What does domestic violence mean?
Domestic violence is an escalating pattern of abuse where one partner in an intimate relationship controls the other through force, intimidation, or the threat of violence.[6] Domestic violence can come in many forms, although is mostly associated with acts that are physical, sexual, emotional, verbal, psychological, and financial (see Appendix C for more details).

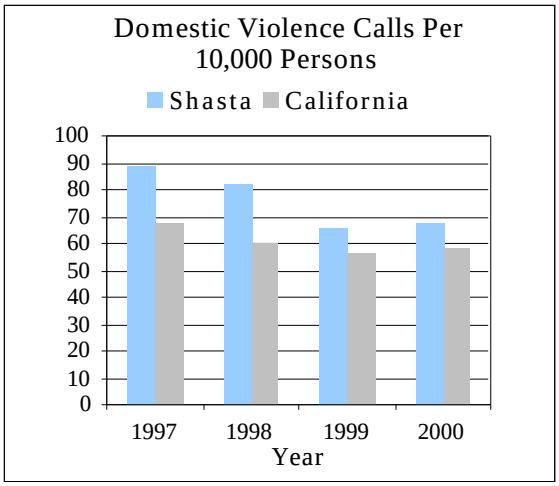
Why is this important?
Children in homes where domestic violence occurs have a greater likelihood of being victims of abuse. A study released in 2000 found that 40% to 60% of reported Child Protective Services (CPS) cases of child maltreatment also included incidents of domestic violence. A similar study found that 50% of men who have assaulted their wives have also assaulted their children[7] (see Appendix C for more information). The information provided on this page does not specifically address children between the ages of zero and five but it is apparent they are involved.

How are we doing?
- From 1997 and 2000, Shasta County experienced a higher rate of domestic violence calls per 10,000 persons than did California as a whole, with an annual average of 76.6 compared to California's annual average of 60.7.
- Between the years of 1997 and 1999, both Shasta County and California showed a decrease in the number of domestic violence incidents; however, Shasta County's decrease was much more significant than the state's. In the year 2000, both Shasta County and California had a slight increase in the number of domestic violence calls per 10,000 persons from the previous year.
- According to the Shasta County Women's Refuge, the drop in the number domestic violence calls per 10,000 persons in Shasta County after 1998 could be attributed to the implementation of the Domestic Violence Accountability Project, which has included enhanced penalties for repeat domestic violence perpetrators.

Domestic Violence Calls Per 10,000 Persons

Year	Shasta County	California
1997	89.4	68.3
1998	82.4	60.2
1999	66.2	56.2
2000	68.4	58.1

Source: RAND California, Child Abuse Statistics; California Department of Justice.



[6]Santa Clara County Probation Department, Domestic Violence Information and Referral Handbook.
[7]Schechter, S. & Edelson, J.L., In the Best Interests of Women and Children: A Call for Collaboration Between Child Welfare and Domestic Violence Constituencies.

Number of licensed infant centers available for children 0 to 24 months

What are licensed infant centers?
According to the general requirements under Title 22 of Community Care Licensing, an infant center is a facility that provides care to children up to a maximum age of three years.

Why is it important?
Today, more children are placed in a paid child care setting than are being cared for by relatives.[8] Consequently, having a safe and nurturing setting outside the home that accentuates the developmental needs of young children has become paramount.

How are we doing?

- In Shasta County, from 1998 to 2001, the number of infant centers grew by 22.2%, or two facilities, resulting in an increased capacity of 33 child spaces. California infant centers grew by 10.0%, or 138 facilities, over the same four-year period, making 6,547 more spaces available for the state's children.

Number of Licensed Infant Centers and Capacity Available for Children 0 to 24 Months, 1998-2001

	Shasta County		California	
Year	Average Capacity	Average # of Licenses	Average Capacity	Average # of Licenses
1998	167	9	26,102	1,381
1999	192	10	28,074	1,336
2000	196	10	30,178	1,420
2001	200	11	32,649	1,519

Source: California Department of Social Services, Community Care Licensing Division.

Note: Yearly totals are based on monthly averages.

[8] Scarr, S., American Child Care Today, 1998.

Number of available accredited child care homes and early care education centers

What does accredited child care facilities mean?
Accredited child care homes and early care education centers are programs that have met the minimum ***licensing*** standards and have voluntarily agreed to provide a higher degree of quality child care. Accredited programs are under more stringent guidelines than licensed programs and must reapply for accreditation every three years. The emphasis of accredited programs is to provide activities and act on opportunities that promote learning and development among children.

Why is it important?
For parents, having infants and children in accredited programs increases confidence that they have placed their child in a safe and enriching environment.[9] Children who attend accredited child care homes and centers are more likely to be attached to their caregivers and have better social skills than children attending other child care homes and centers. Furthermore, children receiving child care at accredited homes and centers also seem to develop language and cognitive skills more quickly than children in other centers.[10]

How are we doing?

- Between the years of 1999 and 2000, California saw an increase in accredited child care centers to 608, an increase of 95 centers from the year before. Between 2000 and 2001, however, the number of centers decreased by 16.
- There were no accredited ***child care centers*** in Shasta County, but 6 family child care homes earned their accreditation in Spring 2001.

Number of Accredited Child Care Facilities, Shasta County and California

	Child Care Centers		Family Child Care	
Year as of June 1	Shasta	California	Shasta	California
1999	0	513	0	n/a
2000	0	608	0	n/a
2001	0	592	6	45

Source: Early Childhood Services – Shasta County Office of Education, 2001; National Association for the Education of Young Children, June 1, 1999, 2000, and 2001; and The National Association for Family Child Care, 2001.

[9] Jacobson, L., Early-Childhood-Accreditation Demand Overwhelms NAEYC, 1999.
[10] Burchinal, M.R., Roberts, J.E., Riggins Jr., R.R, Zeisel, S.A., Neebe, E. & Bryant, D., Relating Quality of Center-Based Child Care to Early Cognitive and Language Development Longitudinally, 2000.

Number of substantiated cases of child abuse and neglect

*What does substantiated **child abuse and neglect** mean?*
Substantiated cases of child abuse and neglect are confirmed incidents of ***physical abuse***; ***sexual abuse***, or exploitation; negligent treatment; or maltreatment of a child by a person who is responsible for the child's welfare.

Why is it important?
Beyond the physical harm that comes to children who are victims of abuse and ***neglect*** are the long-term ramifications to the child's emotional and mental well being. Other common childhood responses to the trauma are high levels of anxiety, Post Traumatic Stress Disorder, and difficulties in school. Children who are subjected to abuse face an increased likelihood of being either violent or passive in nature.[11]

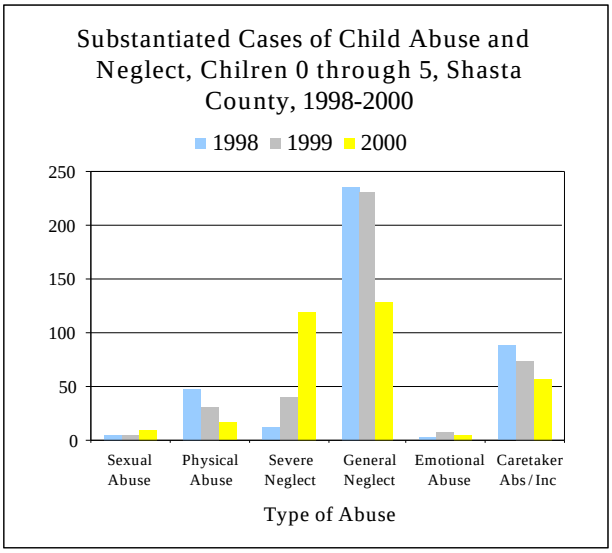
How are we doing?

- General and severe neglect were the most prevalent forms of child abuse and neglect in Shasta County between 1998 and 2000. On average, 64% of the cases of abuse and neglect over the three-year span were general and severe neglect.
- Total cases of abuse remained unchanged in Shasta County in 1998 and 1999 at 419, but dropped to 356 in 2000.

Note: According to Shasta County Department of Social Services, severe neglect may have been incorrectly recorded as general neglect in previous years, but was correctly recorded as severe neglect starting in year 2000. See Appendix C for California data.

Substantiated Cases of Child Abuse and Neglect, Total Number of Cases, Shasta County, 1998-2000

Type of Abuse	1998		1999		2000	
	Under Age 1	Age 1 to 5	Under Age 1	Age 1 to 5	Under Age 1	Age 1 to 5
Sexual Abuse	0	5	0	4	0	10
Physical Abuse	7	41	4	27	2	14
Severe Neglect	9	3	14	27	45	74
General Neglect	76	160	67	165	18	111
Exploitation	0	0	0	0	3	5
Emotional Abuse	0	3	1	6	1	3
Caretaker Absence/Incapacity	14	73	14	60	15	42
At Risk, But Not Abused	0	0	0	1	0	0
Unknown/Missing	4	24	2	27	3	10
Total	110	309	102	317	87	269



Source: Child Welfare/Case Management System.

Note: A child is counted only once (per year per county), in category of greatest severity.

[11] Santa Clara County Probation Department, Domestic Violence Information and Referral Handbook.

Number of vendors providing respite services for families with children 0 to 5

What does respite services mean?
Respite refers to short term, temporary care provided to children with disabilities. Unlike child care, respite services may sometimes involve overnight care or care for an extended period of time (see Appendix D for terms and definitions of types of vendors providing respite services).

Why is it important?
One of the most important purposes of respite care is to provide family members time and temporary relief from the stress they may experience while providing extra care for a child with disabilities. Respite also gives the child a change in daily routine. It can provide the child with opportunities to build new relationships and move toward independence.[12]

How are we doing?

- In Shasta County, there are currently 3 in-home respite service agencies and an additional 17 family members that provide respite services to families with children with disabilities.
- In the fiscal year 2000–2001, in California, 5,029 family members provided respite services to a child with a ***developmental disability*** in their family, the highest in the three-year span.
- In California, there was a small but steady increase in number of in-home respite services vendors (51 in 1998-1999 to 55 in 2000-2001).
- The number of in-home respite workers in the state increased in fiscal year 1999-2000 to 469 and then declined to 253 in 2000-2001.
- The total number of vendors in Shasta County remained at 20 between fiscal year 1998-1999 and 2000-2001.

Number of Vendors Providing Respite Services for Children 0 Through 4 Years Old

	Shasta County			California		
Services	FY 1998-1999	FY 1999-2000	FY 2000-2001	FY 1998-1999	FY 1999-2000	FY 2000-2001
Respite Services - Family Member	18	19	17	4,010	4,677	5,029
In-Home Respite Services Agency	1	1	3	51	52	55
In-Home Respite Worker	n/a	n/a	n/a	307	469	253
Out-of-Home Respite Services	1	0	0	17	13	10
Respite Facility	0	0	0	1	1	1

Source: Department of Developmental Services, Information Systems and Services Branch.

Note: Vendor means an applicant that has completed the vendorization process and has been given a vendor identification number. Vendorization is the process used to verify that an applicant meets all of the requirements and standards and has been assigned vendor identification numbers, service codes, and sub-codes for the purpose of identifying vendor expenditures.

[12] Department of Developmental Services.

Number and percentage of women who smoked during pregnancy

What does women who smoked during pregnancy mean?
Women who reported to had smoked during at least some part of their pregnancy (Shasta County residents) or were currently smoking while pregnant (California residents) were the subjects of this study.

Why is it important?
Women who smoke tobacco during pregnancy have an increased risk of miscarriage, premature birth, and bleeding during childbirth. Infants with mothers who have smoked are at risk for low birth weight, poor lung development, asthma, and infections. Children of women who smoked during pregnancy have an increased likelihood of smoking themselves.[13]

How are we doing?
Note: Data collection for Shasta County is derived from a different source of data than for California and the methodology for data collection was different. When reading the tables and narratives, comparisons should not be directly made between the county and state.

- In Shasta County, there has been a steady decrease in the percentage of women who smoked at some point during their pregnancy. Between the years of 1995 and 1998, women that smoked during pregnancy dropped 5.1 percentage points.
- In California, the percentage of women who claimed to be currently smoking while pregnant decreased from 4.0% in 1996 to 2.9% in 1999.

Percentage and Number of California Pregnant Women Who Currently Smoke Cigarettes, 1996-1999

Year	Percentage Who Are Smoking	Number of Women Smoking	Enrollees in Expanded AFP Screening Program
1996	4.0%	13,601	338,665
1997	3.5%	11,990	338,525
1998	3.3%	11,288	341,767
1999	2.9%	10,220	349,853

Source: California Department of Health Services, Genetic Disease Branch, Prenatal Screening Program, 2001.

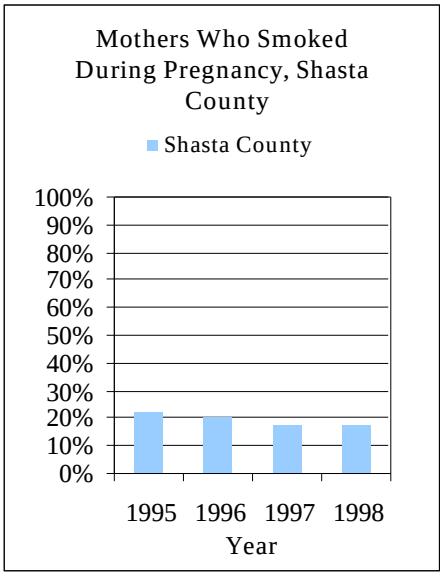
Notes: Data comes from Expanded AFP Screening Program participant responses to the following question: "Does the patient currently smoke cigarettes?"

Approximately 70% of California's pregnant women with live births enroll in the Expanded AFP (Alpha-fetoprotein) Screening Program between 15 and 19 weeks of gestation each year (California Department of Health Services, Program Research and Demonstration Unit, 2001).

Mothers Who Smoked During Pregnancy, Shasta County

Year	Shasta County
1995	22.3%
1996	20.4%
1997	17.6%
1998	17.2%

Source: "The People's Health: A County Health Assessment."



[13]C.W. Henderson, Smoking While Pregnant, 2000.

Percentage of women who used drugs during pregnancy

What does drug use during pregnancy mean?
For the purpose of this study, this definition includes women who reported that they had used alcohol and illegal drugs during some part of their pregnancy.

Why is it important?
For women, using alcohol and illegal drugs during pregnancy may cause premature labor, miscarriage, or the possibility of the placenta tearing from the uterus. A mother's drug use during pregnancy may also cause the following occurrences in the fetus: reduced levels of nutrients and oxygen, strokes, brain damage, or death. Low-birth weight has been linked to drug use during pregnancy, as has the increased likelihood of the child developing behavioral abnormalities and learning disabilities.[14]

How are we doing?

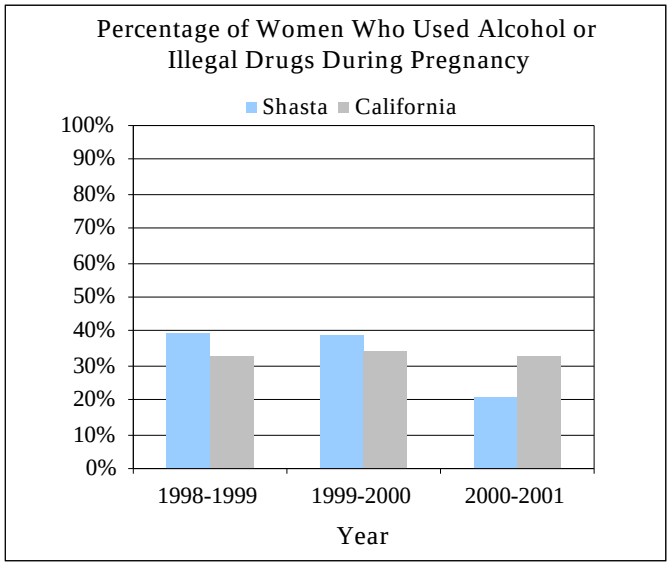
- In Shasta County, there was a major decrease in reported alcohol and illegal drug usage in fiscal year 2000-2001. During this year, only 21.2% of women reported to have used drugs during pregnancy, an 18.2 percentage point drop from the two previous fiscal years, both of which had usage rates of 39.4%. As of this time, the California Department of Alcohol and Drugs is unable to account for the significant drop between fiscal years 1999-2000 and 2000-2001.
- In California, from 1998 to 2001, between 32.6% and 33.9% of pregnant women reported to have used alcohol or drugs during pregnancy.

Percentage of Women Who Used Alcohol or Illegal Drugs During Pregnancy

Year	Shasta County	California
1998-1999	39.4%	33.4%
1999-2000	39.4%	33.9%
2000-2001	21.2%	32.6%

Source: California Department of Alcohol and Drugs, Office of Applied Research, California Alcohol and Drug Data System (CADDS), 2001.

Note: Women respondents surveyed were in programs that were publicly funded through the State of California and/or were in programs that dispensed methadone.



[14]University of Iowa, Drugs During Pregnancy, 1999.

Number of women who initiate breastfeeding

*What does **breastfeeding initiation** mean?*
Historically, breastfeeding initiation has been defined as women who have attempted to breastfeed their infants, whether successful or not, at least once during the first hours or days of the infant's life. In the study cited below, a woman was recorded as having initiated breastfeeding if she successfully breastfed her infant within two hours of the child's birth.

Why is it important?
The American Academy of Pediatrics currently recommends breastfeeding for at least the first year of an infant's life. Breast milk has antibodies that are passed from the mother to the child and help protect against illnesses and allergies. Breast milk is easily digested and breastfed babies have good cheekbone development and jaw alignment. The longer a baby receives breast milk, the greater the benefits.[15] Breastfeeding helps the mother and child bond and there are many physical benefits for the breastfeeding mother as well (see Appendix E for a more detailed explanation).

How are we doing?

- It is difficult to know how we are doing as a county because of the existing data collection and reporting methodology. The data that the state reports as the percentage of women who have initiated breastfeeding in Shasta County is actually the percentage of women who intended at some point during their pregnancy to breastfeed their children.
- Beginning in April 2001, a Breastfeeding Surveillance Study surveyed women who gave birth at Mercy Medical Center in Redding. The study measured the number of successful breastfeeding initiations, as well as recorded breastfeeding duration.

Findings from the Breast Feeding Surveillance Study

53% of infants born at Mercy Medical Center between the April 1st, 2001 and September 30th, 2001 breastfed within 2 hours of being born.

Source: The Breastfeeding Surveillance Study, Shasta County Department of Public Health and Mercy Medical Center, 2001.
Note: Of the 922 mothers giving birth to children at Mercy Medical Center, 41.1% or 379 mothers, refused to take part in the study.

[15] "The Advantages of Breastfeeding," La Leche League, International, 2001.

Number of women who breastfeed their infants until 6 months and 11 months of age

What does breastfeeding until 6 and 11 months accomplish?
Breastfeeding is a natural way for a mother to supplement her child's diet as the child transitions to solid foods.

Why is it important?
The American Academy of Pediatrics currently recommends breastfeeding for at least the first year of an infant's life, because the longer a baby receives breast milk, the greater the benefits. Breast milk has antibodies that are passed from the mother to the baby and help protect the baby against illness and allergies.[16] Furthermore, breastfeeding creates a bond and strengthens attachment between the mother and baby (see Appendix E for other benefits of breastfeeding).

How are we doing?
Note: The data represented below is the data for a cohort of 6 and 11 month old infants of the WIC child population for whom data was available. Therefore, this dataset is not representative of the general population in Shasta County.

- Between May 1999 and February 2001, for every 1,000 births from WIC mothers in Shasta County, 163 of these infants were breastfed until 6 months of age and 120 were breastfed until 11 months of age.
- In Shasta County, black mothers participating in WIC were much more likely to breastfeed their infants up to 6 months and 11 months then were WIC Asian mothers. Both of these ethnic/racial groups also have the two smallest populations of WIC children in the county.

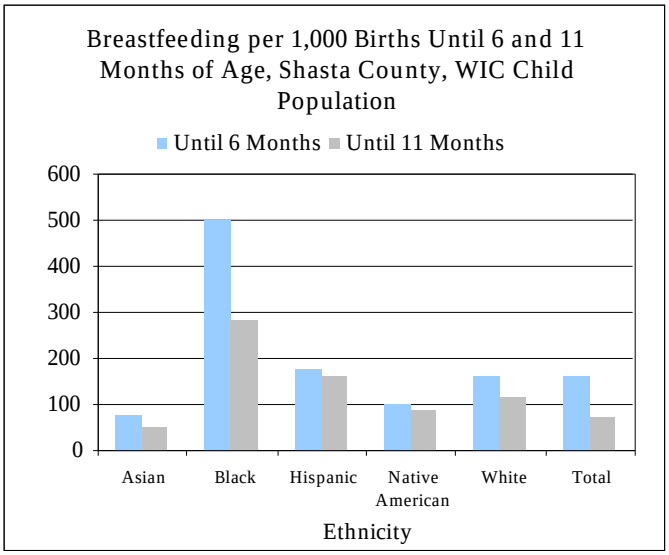
Breastfeeding Until 6 and 11 Months of Age, Shasta County WIC Child Population for Whom Data was Available, May 1999 Through February 2001

Ethnicity	Breastfeeding Until 6 Months			Breastfeeding Until 11 Months		
	Children Breastfed	Total Births *	Rate Per 1,000	Children Breastfed	Total Births **	Rate Per 1,000
Asian	3	39	76	3	62	48
Black	11	22	500	12	42	285
Hispanic	28	158	177	50	314	159
Native American	12	119	100	17	196	87
White	255	1,555	163	337	2,871	117
Total	309	1,893	163	419	3,485	120

Source: Shasta County Department of Health Services.

** Includes births between 12/1/1998 and 11/31/1999.*

*** Includes births between 6/1/1998 and 3/31/2000.*



[16] "The Advantages of Breastfeeding," La Leche League, International, 2001.

Number of reported cases of children under age 5 with blood lead levels exceeding 10ug/dl per 100,000 children

What does elevated blood lead levels mean?
Lead is a heavy, durable, soft metal that is usually found in some form in homes (e.g., pipes, paint) and in the environment (e.g., water, soil, gasoline). There are two ways that lead usually enters the body, through breathing or ingestion. In both cases, lead is quickly absorbed into the blood stream. In 1991, the Centers for Disease Control and Prevention (CDC) redefined elevated blood lead levels as those greater than or equal to 10 micrograms of lead per deciliter of blood (µg/dl).

Why is it important?
Even small doses of lead can seriously affect the brain, nervous system, and certain areas of the body[17] (see Appendix F for details). Children exposed to high levels of lead are at risk for hyperactivity, lethargy, hearing loss, and memory loss, as well as learning disabilities.[18]

How are we doing?

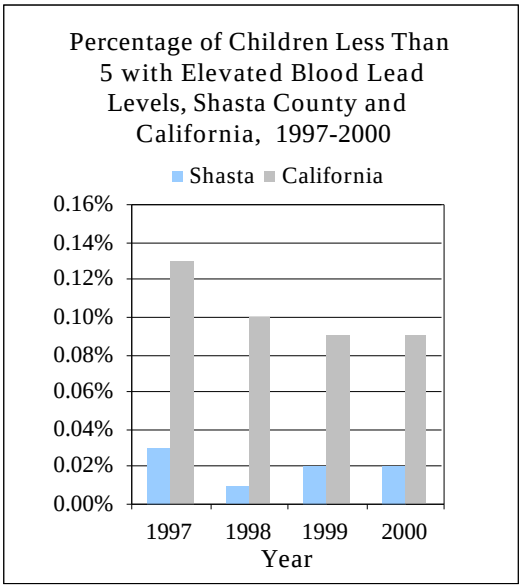
- There were a small percentage of children with elevated blood lead levels in both Shasta County and California between 1997 and 2000. However, Shasta County levels were on average one-fifth as high as state levels. Over the four-year period, 0.02% of Shasta County children under 5 had elevated blood lead levels while in California, 0.10% had elevated blood lead levels.

Number of Children Less Than 5 Years of Age with Elevated Blood Lead Levels, Shasta County

Year	Shasta County		California	
	Number of Children with Elevated Blood Lead Levels	Percent of Children with Elevated Blood Lead Levels	Number of Children with Elevated Blood Lead Levels	Percent of Children with Elevated Blood Lead Levels
1997	3	0.03%	3,139	0.13%
1998	1	0.01%	2,531	0.10%
1999	2	0.02%	2,226	0.09%
2000	2	0.02%	2,142	0.09%

Source: California Department of Health Services, Childhood Lead Poisoning Prevention Branch.

Note: The Center for Disease Control and Prevention defines elevated blood lead levels as those greater than or equal to 10 micrograms of lead per deciliter of blood (µg/dl).



[17] CONNOR Environmental Services and Engineering Assessments, Lead Hazard Awareness Training, 2000.
[18] Journal of Environmental Health, Ongoing Efforts to Prevent Childhood Lead Exposure, 1999.

Number of reported cases of children 0 to 5 who were anemic

What does anemia mean?
Anemia is a low hemoglobin (Hb) concentration or a low hematocrit (Hct) or red blood cell level that indicates an iron deficiency. For children age 1 to 2 years, anemia is defined as an Hb concentration less than 11.0 g/dL or an Hct level less than 33% of whole blood. For children 2 through 4 years of age, anemia is defined as an Hb concentration less than 11.2 g/dL or an Hct level less than 34%.[19]

Why is it important?
Iron deficiency can cause developmental delays in infants and small children. A recent study indicated a correlation between anemia and below average math comprehension in school-aged children.[20]

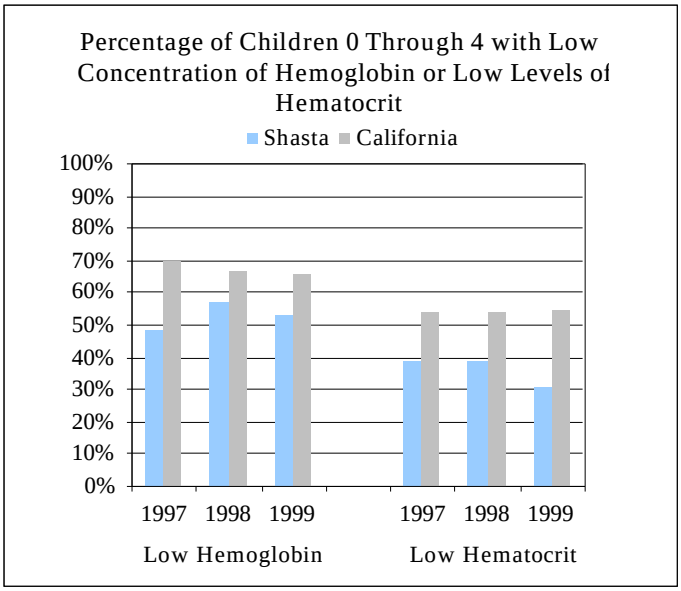
How are we doing?

- In Shasta County, the percentage of children who were tested for anemia and had low concentrations of Hb increased between 1997 and 1998 by 8.2 percentage points and then decreased 3.9 percentage points by 1999.
- The percentage of Shasta County children examined for anemia and having low concentrations of Hct was unchanged from 1997 to 1998 (39.4 percent) but decreased by 8.4 percentage points in 1999.
- Shasta County had significantly lower percentages of children with low levels of Hb as well as low levels of Hct compared to California (see Appendix G for more detailed tables).

Percentage of Children 0 Through 4 Tested for Anemia with Low Concentrations of Hemoglobin and Hematocrit

	Shasta County		California	
Year	Low Hb	Low Hct	Low Hb	Low Hct
1997	48.8%	39.4%	70.0%	53.7%
1998	57.0%	39.4%	67.3%	53.6%
1999	53.1%	31.0%	65.6%	55.2%

Source: Pediatric Nutrition Surveillance.



[19] Pediatric Nutrition Surveillance.
[20] Halterman, J.S., Kaczorowski, J.F., Szilagyi, P.G., Aligne, A.C. & Auinger, P., Iron Deficiency and Cognitive Achievement Among School-Ages Children and Adolescents in the United States, 2001.

Adult literacy rates for parents of newborn children

What does adult literacy mean?
Literacy is defined as an individual's ability to read, write, speak in English, and compute and solve problems at levels of proficiency necessary to function on the job and in society.[21] For the purposes of this study, the number of years completed in school by parents of newborns is being used to measure adult literacy.

Why is it important?
Problems such as poverty, illiteracy, poor education, and social risks have been inextricably linked in the United States. For example, the majority of the illiterate adults in this country are living in poverty. Children, too, may suffer from their parent's lack of education. Children from homes with illiterate adults are more likely to be less prepared for school and have a greater likelihood of dropping out of school than children coming from homes with literate adults.[22]

How are we doing?

- On average, over the three-year span from 1997 to 1999, 76.7% of Shasta County parents of newborns had completed 12 or more years of education. For California, over the same time frame, 66.6% of parents had completed 12 years of education or more.
- Whereas Shasta County parents were more likely (on average 25% in Shasta County and 19.5% in California) to have attempted a higher degree (13-15 years of education), more parents in the state completed 16 or more years of education (on average 13.7% in Shasta County and 18.9% in California). This is probably due to the residents attending one or two years at the junior college in the Redding area.

Live Births by Mother's Education, Shasta County and California, 1997-1999

Mother's Education in Years Completed	1997		1998		1999	
	Shasta	CA	Shasta	CA	Shasta	CA
None	0.1%	0.6%	0.1%	0.5%	0.2%	0.4%
1-3 Years	0.3%	1.6%	0.3%	1.5%	0.2%	1.4%
4-6 Years	0.8%	8.1%	0.5%	7.5%	0.8%	7.4%
7-9 Years	4.7%	9.5%	3.5%	9.1%	3.0%	9.1%
10-11 Years	16.8%	12.0%	17.4%	11.9%	15.9%	11.5%
12 Years	37.9%	28.8%	37.9%	28.9%	37.5%	28.8%
13-15 Years	25.9%	19.5%	26.5%	19.6%	28.9%	19.6%
16 Years and Over	13.0%	18.5%	13.6%	19.2%	12.9%	20.1%
Unknown	0.7%	1.4%	0.3%	1.7%	0.6%	1.5%

Source: State of California, Department of Health Services, Birth Records.

Live Births by Father's Education, Shasta County and California, 1997-1999

Father's Education in Years Completed	1997		1998		1999	
	Shasta	CA	Shasta	CA	Shasta	CA
None	0.3%	0.3%	0.3%	0.4%	0.3%	0.5%
1-3 Years	0.4%	0.4%	0.1%	1.4%	0.2%	1.4%
4-6 Years	1.0%	1.0%	0.5%	7.3%	1.2%	7.2%
7-9 Years	2.0%	2.0%	2.5%	7.5%	2.1%	7.7%
10-11 Years	12.3%	12.3%	12.5%	8.5%	10.0%	8.2%
12 Years	38.3%	28.3%	38.4%	28.4%	37.8%	28.5%
13-15 Years	22.6%	22.6%	21.9%	16.5%	24.4%	16.5%
16 Years and Over	13.8%	13.8%	14.4%	20.5%	14.5%	21.0%
Unknown	9.6%	9.6%	9.4%	9.4%	9.5%	9.0%

Source: State of California, Department of Health Services, Birth Records.

[21] National Institute for Literacy, The State of Literacy in America: Estimates at the Local, State, and National Levels.
[22] DeBruin-Parecki, A. & Paris, S., Family Literacy Levels: Examining Practice and Issues of Effectiveness (1997).

Number of children receiving early dental assessments in Shasta County

What do early dental assessments mean?

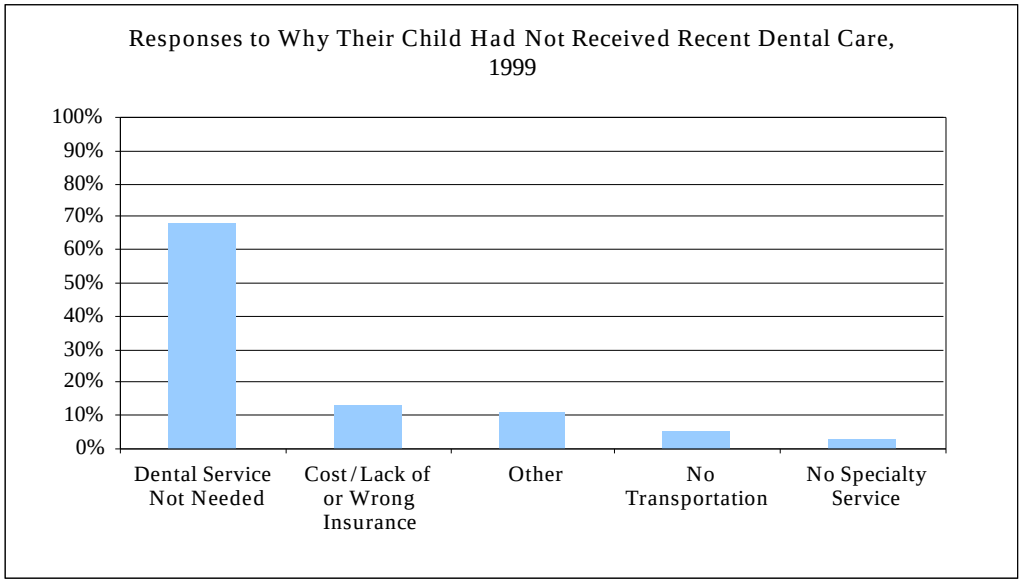
For the purpose of this study, early dental assessments mean children who have visited a dentist for a routine check up in the last six months.

Why is it important?

During tooth formation, proper health and an effective dental regime are important in securing the best chance for healthy teeth in children. Consequently, periodic visits to the dentist are essential in assisting children in achieving optimal dental development.

How are we doing?

- According to a report released in 1999 by the Catholic Healthcare West/Professional Research Consultants, 29.5% of children ages 1 to 5 had visited a dentist for a routine check-up within the past six months.
- When Catholic Healthcare West/Professional Research Consultants asked parents why they had not taken their child to the dentist in the last six months, 68.1% said their child did not need dental care, 13.4% responded that cost/no insurance/wrong type of insurance was the reason for not visiting the dentist; 4.8% parents said it was a lack of transportation; and 3.1% said lack of specialized dental services was the reason for not taking their child for a routine check-up. Another 10.6% of parents specified other reasons.
- Currently there is only one pedodonist available to families in Shasta County.[23] Adding to this dilemma, many Head Start families with children ages 1 to 5 are unable to find a dentist who will accept Denti-Cal. Thus, the need to provide affordable dental services to those children who would benefit the most from the preventative care is often unmet.



[23] Catholic Healthcare West/Professional Research Consultants, Community Health Assessment, 1999.

Number of pregnant women who received prenatal care during their first trimester of pregnancy (early prenatal care)

*What does **early prenatal care** mean?*
Early prenatal care is defined as at least one prenatal care visit during the first trimester (3 months) of pregnancy. Adequate prenatal care is usually defined as starting care in the first three months of pregnancy and at least 9 visits for women giving birth to full-term infants after 40 weeks.

Why is it important?
Receiving late prenatal care, or receiving no prenatal care at all, can lead to negative health outcomes for mother and child. Women who receive care late in pregnancy or who do not receive care at all are at an increased risk of stillbirth, infant death, and low birth weight.[24]

How are we doing?

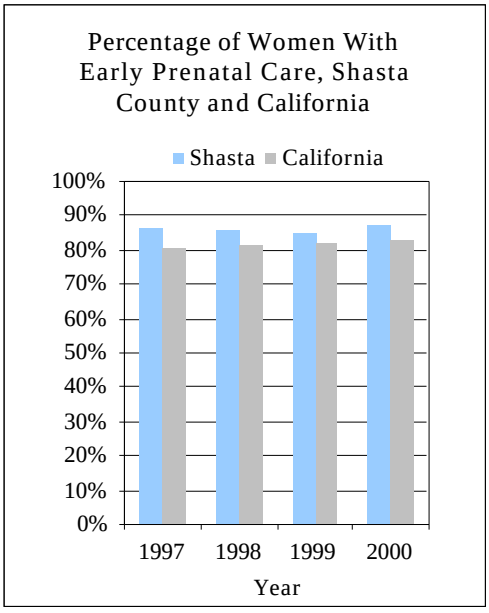
- Although Shasta County had a slightly higher percentage of women accessing early prenatal care than California, the state showed a steady increase over the four-year span, from 80.8% in 1997 to 83.2% in the year 2000. In Shasta County, the percentage of women seeking early prenatal care decreased during 1998 and 1999 before rebounding to a four-year high in 2000.
- On average, the percentage of women who gave birth and had early prenatal care in Shasta County over the four-year period was 86.2%. This percentage was lower for California women at 81.9%.

Early Prenatal Care, Shasta County and California, 1997-2000

Year	Shasta County			California		
	Total Births	Early Prenatal Care	Percent of Total Births	Total Births	Early Prenatal Care	Percent of Total Births
1997	1,990	1,720	86.4%	522,958	422,787	80.8%
1998	1,932	1,654	85.6%	520,075	421,979	81.1%
1999	1,840	1,571	85.4%	515,504	424,218	82.3%
2000	1,828	1,594	87.2%	530,642	441,311	83.2%

Source: California Department of Health Services, Birth Records.

Note: Data is collected by zip codes. Zip codes with less than 5 births are not included.



[24] "Prenatal Care Rates," The Wealth of Humboldt and the Klamath-Siskiyou Region.

Number of pregnant women who began prenatal care after the first trimester of pregnancy (late prenatal care) or receive no prenatal care during pregnancy

What does late or no prenatal care mean?
Late prenatal care is defined as prenatal care that begins after the first trimester (the first 3 months) of pregnancy. No prenatal care is defined as no visitations to a hospital, clinic, or any other pregnancy-related agency prior to the delivery of the child.

Why is it important?
Adequate prenatal care is believed to result in better pregnancy outcomes including reduced maternal and infant ***morbidity and mortality***; reduced risk for pre-term delivery; and lower chances of children born with low birth weight.[25]

How are we doing?

- The percentage of women in Shasta County who received late prenatal care showed an overall decrease from 12.6 % in 1997 to 12.0 % in 2000. The decrease for California is more consistent from 17.1 % in 1997 to 14.6 % in 2000.
- The percentage of women in Shasta County who did not receive prenatal care at any point during their pregnancy stayed at 0.7 % during a three year period, 1997 to 1999, and decreased to 0.5 % in 2000, while California decreased from 0.9 % to 0.6 %.
- When compared to California, fewer women in Shasta County began prenatal care after the first trimester or received no care during pregnancy. However, the rate of decrease in the state is much more rapid, decreasing 2.5 percentage points, than in Shasta County, which decreased 0.6 percentage points.

The data tables are located on the following page.

[25] "Prenatal Care Rates," The Wealth of Humboldt and the Klamath-Siskiyou Region.

Late or No Prenatal Care, Shasta County, 1997-2000

Year	Shasta County Total Births	Late Prenatal Care		No Prenatal Care	
		Number	Percent of Total Births	Number	Percent of Total Births
1997	1,990	250	12.6%	13	0.7%
1998	1,932	260	13.5%	13	0.7%
1999	1,840	254	13.8%	13	0.7%
2000	1,828	220	12.0%	9	0.5%

Source: California Department of Health Services, Birth Records.

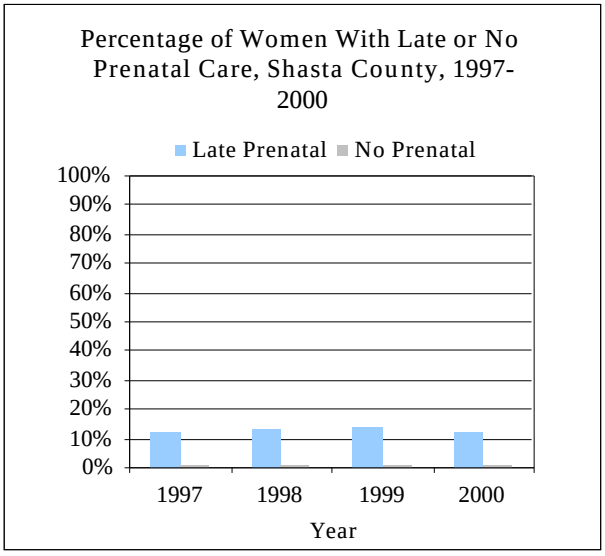
Note: Data is collected by zip code. Zip codes with less than 5 births are not included.

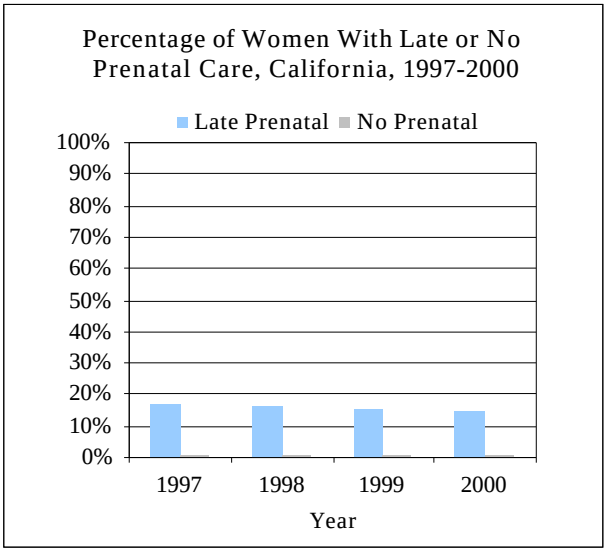
Late or No Prenatal Care, California, 1997-2000

Year	California Total Births	Late Prenatal Care		No Prenatal Care	
		Number	Percent of Total Births	Number	Percent of Total Births
1997	522,958	89,502	17.1%	4,539	0.9%
1998	520,075	85,794	16.5%	4,342	0.8%
1999	515,504	79,598	15.4%	3,295	0.6%
2000	530,642	77,371	14.6%	3,159	0.6%

Source: California Department of Health Services, Birth Records.

Note: Data is collected by zip code. Zip codes with less than 5 births are not included.





Number of 4-year-old children enrolled in Head Start

*What does **Head Start** enrollment mean?*
Head Start is a partial-day comprehensive child development program for children 3 to 5 years of age from low-income families.[26] Each participant must voluntarily enroll in the program. Eligibility guidelines for enrollment into Head Start programs goes as follows:

- If a family is a TANF recipient or a child is in foster care, either is automatically eligible for Head Start.
- First priority in eligibility for Head Start is based on family's income. If a family's income falls below the Department of Health and Human Services' poverty guidelines they are eligible for services. For example, in 2002, if a family of four's income level is below $18,100, they hold first priority, beyond those automatically eligible, in gaining access to Head Start programs.
- Second priority criteria are based on those families with "high social service needs" (overcrowded or unstable living conditions, geographic isolation, parental disability, etc.) or possessing inadequate health care.

Why is it important?
Head Start is designed to help break the cycle of poverty by providing preschool children of low-income families with a comprehensive program to meet their emotional, social, health, nutritional, and psychological needs.[27] In 1998, policy makers articulated that school readiness should be the primary goal for Head Start programs. Head Start works to enhance the development of preschool children from families living in poverty in the context of strong family support and parent involvement.[28]

How are we doing?

- The total number of 4-year-old children enrolled in Head Start in Shasta County increased by 24 children in 1999 and showed no change in 2000. Total growth in number of enrolled children between 1998 and 2000 is 2.8%.
- Of the total number of 4-year-old children living in Shasta County, 32.6% were enrolled in Head Start in 1998, 35.1% were enrolled in 1999, and 35.4% in 2000.
- In California, the total number of children enrolled in Head Start increased more quickly since 1998 than in Shasta County.

Head Start Enrollment for Children, California, FY 1997-2000

Year	Total Head Start Enrollment
1997	79,929
1998	86,368
1999	88,860
2000	95,280

Source: Head Start; Research and Statistics; Statistical Fact Sheets.

Total 4 Year Olds, Total 4 Year Olds in Head Start, Percentage of Children 4 Years of Age Enrolled in Head Start, Shasta County, 1998-2000

Year	Total 4 Year Olds	4 Year Olds Enrolled in Head Start	Percent Enrolled
1998	1,132	369	32.6%
1999	1,120	393	35.1%
2000	1,110	393	35.4%

Source: Census 2000; Head Start; Research and Statistics; Statistical Fact Sheets; Shasta Head Start.
Note: There are no reliable estimates of total 4 year olds in 1998 and 1999. Number of 6 year olds in Census 2000 was used for 4 year olds in 1998 and number of 5 year olds in Census 2000 was used for 4 year olds in 1999.

[26] Shasta Head Start Child Development.
[27] California Head Start Association.
[28] Parker, Boak, Faith, and Lamb, Parent-Child Relationship, Home Learning Environment, And School Readiness, 1998.

Number of children who have obtained the recommended immunizations by age of two

What does immunizations recommended by the age of two mean?
Children who are completely immunized by 24 months of age (two years) have completed the following immunizations: four doses of diphtheria, tetanus, and pertussis (DTP); three doses of polio; and one dose of measles, mumps, and rubella (MMR).

Why is it important?
The immune system of young children is not strong enough to defend against diphtheria, measles, rubella, and the other diseases immunizations are available for. Immunization is a way to assure the defense against these diseases and ensure good health for the child. According to the American Academy of Pediatrics immunization helps protect children from infections that can lead to serious complications. Although the vaccines may have mild side effects, in general it is safer to immunize children than allow for the risk of infection.[29]

How are we doing?

- There was a 3.0 percentage point increase in immunization by the age of two between 1997 and 2000 for children served by Shasta County Public Health. Data for the other immunization clinic in Shasta County, Shasta Community Health Center, is limited to two years.
- A California comparison can be found in 2000, but only for children in child care centers where 94.1% of children are immunized by age five compared to 94.2% in Shasta County.

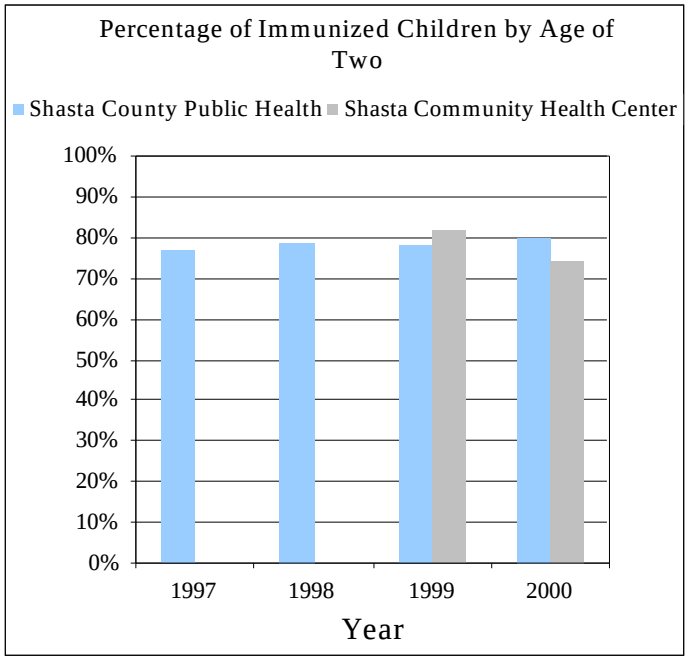
Percentage of Two-Year Old Children Who were Up-To-Date for Immunizations on Their Second Birthdays, 1997-2000

Year	Shasta County Public Health	Shasta Community Health Center
1997	76.7%	n/a
1998	78.8%	n/a
1999	77.8%	81.9%
2000	79.7%	74.2%

Source: California Department of Health Services, Immunization Branch.

Note: Percentage of two-year old children under care at major Shasta County vaccine providers who were up-to-date with immunizations.

Shasta Community Health Center is a nonprofit primary health care system serving Shasta and surrounding counties.



[29] California Department of Health Services, Kindergarten Retrospective Surveys.

Appendix A – Medi-Cal Enrollment and Eligibility Standards

Medi-Cal provides access to health care services for people whose assets and income are insufficient to pay medical bills and meet basic monthly needs. Individuals already receiving cash assistance through CalWORKs are automatically eligible for Medi-Cal. Medi-Cal is a federally and state-funded health insurance program for people who meet at least one item of the following items of criteria: are low-income, elderly, disabled, or enrolled in TANF (Temporary Assistance to Needy Families).

Eligibility standards:

- Pregnant women with incomes ≤ 200% of Federal Poverty Level (FPL),
- Children ages 1-5 with family incomes ≤ 133% FPL, and
- Children ages 6-19 and parents in families with incomes ≤ 100% FPL.

Detailed information on Medi-Cal enrollment for children age 0 to 48 months and pregnant women in Shasta County is shown in the following table.

Children Ages 0 Through 48 Months Enrolled in Medi-Cal, 1998-2001 Monthly Averages, Shasta County

Ages	1998	1999	2000	2001
Children 0 to 11 Months	715	672	585	615
Children 12 to 23 Months	784	712	669	649
Children 24 to 35 Months	819	716	650	684
Children 36 to 47 Months	838	755	676	677
Children 48 Months	66	65	58	56
Total Children 0 Through 48 Months	3,222	2,920	2,638	2,681

Source: California Department of Health Services.

Note: Yearly breakdown for Medi-Cal eligible children is only available for ages 0 through 48 months.

Appendix B – Definitions of Family Care and Child Care Vendors for Children with Special Development Needs

Family member care for children with special developmental needs means that an individual:

- Has a person with a developmental disability residing with him or her,
- Is responsible for the 24-hour care and supervision of a person with a developmental disability,
- Is not a licensed or certified resident care facility or foster family home receiving funds from any public agency or regional center for the care and supervision provided.[30]

Child care for children with special developmental needs means that a vendor:

- Possesses a valid family child care license issued by the Department of Social Services (DSS) or by an agency authorized by DSS to assume specified licensing responsibilities and provision of non-medical care and supervision to children under 18 years of age on a less than 24-hour per day basis in the vendor's own home;
- Possesses a valid license for children issued by DSS or by an agency authorized by DSS to assume specific licensing responsibilities and provision of personal care, protection, supervision, and assistance to children under 18 years of age with special developmental needs in a nonresidential facility; or
- Possesses a preschool license issued by the Department of Education or a valid child care center license issued by DSS or an agency authorized by DSS to assume specified licensing responsibilities in aiding children in development of pre-academic skills, group training, and social skills in a nonresidential facility.

[30] Department of Developmental Services, Information Systems and Services Branch.

Appendix C – Substantiated Cases of Child Abuse and Neglect in California and the Breakdown of the Percentages of Substantiated Cases in Shasta County

How is California doing?
From 1998 to 2000, the number of substantiated cases of sexual abuse, physical abuse, and caretaker absence/incapacity for children fewer than 1 years of age and ages 1 to 5 in California has been decreasing at a slow, but steady rate.

Over the three-year time span, general neglect was the most prevalent form of substantiated child neglect among children 0 to 5 in California, averaging 42.9% of all substantiated neglect and abuse cases.

Over the period of the study, children under 1 had a much higher probability of being victims of severe neglect than did children 1 to 5. Of all substantiated cases for children less than 1 year of age, 18.1% were for severe neglect, compared to 5.4% for children 1 to 5.

Children under 1 had a slightly greater likelihood of being victims of caretaker absence/incapacity than children 1 to 5. From 1998 to 2000, for children under 1 an average 14.9% of all substantiated cases were for caretaker absence/incapacity. For children 1 to 5, the average was 12.1%.

Substantiated Cases of Child Abuse and Neglect, Percent of Total Number of Cases, California, 1998-2000

	1998		1999		2000	
Type of Abuse	Under Age 1	Age 1 to 5	Under Age 1	Age 1 to 5	Under Age 1	Age 1 to 5
Sexual Abuse	0.6%	6.3%	0.4%	5.9%	0.4%	4.9%
Physical Abuse	7.1%	13.9%	6.3%	12.6%	5.8%	11.0%
Severe Neglect	17.7%	5.3%	18.6%	5.5%	18.1%	5.3%
General Neglect	45.6%	39.8%	46.1%	39.6%	45.2%	41.1%
Exploitation	0.1%	0.2%	0.1%	0.1%	0.0%	0.1%
Emotional Abuse	8.0%	12.7%	9.6%	15.1%	9.6%	16.1%
Caretaker Absence/Incapacity	16.5%	13.3%	14.3%	11.8%	13.8%	11.2%
At Risk, But Not Abused	4.2%	8.5%	4.8%	9.5%	3.9%	7.5%
Unknown/Missing	0.0%	0.0%	0.0%	0.0%	3.1%	2.8%
Total	100%	100%	100%	100%	100%	100%

Source: Child Welfare/Case Management System.

Note: A child is counted only once (per year per county), in category of greatest severity.

Appendix D – Definition of Types of Respite Service Providers

Family member–an individual who:

- Has a person with a developmental disability residing with him or her;
- Is responsible for the 24-hour care and supervision of a person with a developmental disability person; and
- Is not a licensed or certified resident care facility or foster family home receiving funds from any public agency or regional center for the care and supervision provided.

In-Home Respite Services – intermittent or regularly scheduled temporary non-medical care and supervision provided in the client's own home and designed to do all of the following:

- Assist family members in maintaining the client at home;
- Provide appropriate care and supervision to protect the client's safety in the absence of family members;
- Relieve family members from the constant, demanding responsibility of caring for a client; and
- Attend to the client's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by the family member.

In-Home Respite Services Agency – a vendor shall be classified as an in-home respite services agency if the appropriate requirements are met. Separate vendorization may be waived at the vendor's request for existing in-home respite services agency vendors requesting to provide new in-home respite services at an additional business address.

In-Home Respite Worker – a vendor shall be classified as a in-home respite worker if the vendor is an individual who:

- Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training, including, but not limited to, the American Red Cross;
- Has the skill, training, or education necessary to perform the required services; and
- Provides in-home respite services.

Out-of-Home Respite Services – a vendor shall be classified as a provider of out-of-home respite services if the vendor:

- Is licensed by Department of Social Services (DSS), by an agency authorized by DSS, or by DHS to provide out-of-home care to persons with developmental disabilities;
- Is providing services in any one of the following capacities of care: Adult Day Care, Child Care, Residential Facility Serving Adults, Residential Facility Serving Children, Intermediate Care Facility/Developmentally Disabled-Habilitative (ICF/DD-H), or Intermediate Care Facility/Developmentally Disabled-Nursing (ICF/DD-N);
- Has staff who have received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training, including, but not limited to, the American Red Cross;
- Has the training, education, and skill to perform the required services; and

- Provides out-of-home respite services that consist of intermittent or regularly scheduled temporary care to individuals in a licensed facility, which is designed to relieve families of the constant responsibility of caring for a member of that family.

Respite Facility – a vendor shall be classified as a respite facility if the vendor:

- Is licensed as a residential facility by DSS or by an agency authorized by DSS;
- Provides only out-of-home respite services (see above); and
- Is not vendored as a residential facility serving adults or residential facility serving children.

Appendix E – The Importance of Breastfeeding

- Breast milk is best for a baby. Breast milk has antibodies that are passed from the mother to the baby that help protect the baby against illness and allergies.
- Breast milk is easily digested. Mothers don't have to worry about their babies being constipated or thirsty because babies acquire an adequate amount of water from breast milk.
- Sucking at the breast helps with oral development. Breastfed babies have fewer speech impediments. Breastfed babies have good cheekbone development and jaw alignment. Consequently, there is less chance of needing braces and other orthodontia work.
- Breastfeeding also is good for the mother. The baby's sucking causes uterine contractions right after birth. The contractions lead to less bleeding for the mother and return the uterus to its pre-pregnancy shape much faster.
- Breastfeeding burns calories. A mother can lose much of her pregnancy weight faster than if she were bottle-feeding her baby.
- Breastfeeding creates a bond between mother and baby by helping the mother learn her baby's cues and signals more quickly.
- Breastfeeding has been shown to be protective against many illnesses, including painful ear infections, upper and lower respiratory ailments, allergies, intestinal disorders, colds, viruses, infections, diabetes, juvenile rheumatoid arthritis, childhood cancers, meningitis, pneumonia, urinary tract infections, salmonella, Sudden Infant Death Syndrome (SIDS), Crohn's Disease, ulcerative colitis, some lymphomas, insulin dependent diabetes, and, for girls, breast and ovarian cancer.
- Through breast milk, a baby is given immunities to illnesses the mother is immune to and those to which she has been exposed. Nursing also allows a baby to give germs to the mother so that her immune system can respond and synthesize antibodies. Consequently, if a baby has come in contact with something that the mother has not, a baby will pass these germs on at the next nursing. During that feeding, the mother’s body will start to manufacture antibodies for that particular germ. By the time the next feeding arrives, the mother’s entire immune system will be working to provide immunities for her and her baby. If a mother is exposed to any bacteria or viruses, her body will make antibodies to ward off the virus, which in turn will enter the baby through the mother’s milk. Breast milk also contains a host of other immune molecules that also help protect a baby from germs.
- A breastfed baby’s immune system develops more rapidly than does a baby who is strictly formula fed.

Appendix F – Children and Incrementally Higher Blood Lead Levels

Every child reacts differently to lead poisoning. The following are some examples of a child's reactions to incrementally higher blood lead levels:[31]

- 10 µg/dl – loss in IQ, hearing problems, and growth problems;
- 20 µg/dl – hyperactivity, poor attention span, difficulty in learning, language and speech problems, and slower reflexes;
- 40 µg/dl – poor bone and muscle development, clumsiness, lack of coordination, early anemia, fewer red blood cells to carry oxygen and iron, fatigue, and drowsiness;
- 50 µg/dl – stomach aches and cramps, anemia, destruction of red blood cells, and brain damage;
- 150 µg/dl – swelling of the brain, seizures, coma, and death.

[31] California Department of Health Services, Childhood Lead Poisoning Prevention Branch.

Appendix G – Complete Data Summary on Anemia in Shasta County and California

Summary of Indicators on Anemia, Shasta County, 1997-1999

Shasta County	1997				1998				1999			
	Low Hemoglobin		Low Hematocrit		Low Hemoglobin		Low Hematocrit		Low Hemoglobin		Low Hematocrit	
Age	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0 - 2 Months	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
3 - 5 Months	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
6 - 11 Months	381	0.7%	301	11.3%	542	13.7%	201	10.7%	442	14.7%	237	9.3%
12 - 23 Months	511	12.3%	336	10.4%	717	15.3%	339	15.0%	570	12.1%	250	6.8%
24 - 35 Months	344	18.3%	222	10.0%	526	15.6%	223	13.0%	369	14.4%	168	6.5%
35 - 59 Months	771	17.5%	442	7.7%	1,031	12.4%	414	0.7%	831	11.9%	379	8.4%
Total	2,007	48.8%	1,301	39.4%	2,816	57.0%	1,177	39.4%	2,212	53.1%	1,034	31.0%

Source: Pediatric Nutrition Surveillance.

Summary of Indicators on Anemia, California, 1997-1999

California	1997				1998				1999			
	Low Hemoglobin		Low Hematocrit		Low Hemoglobin		Low Hematocrit		Low Hemoglobin		Low Hematocrit	
Age	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0 - 2 Months	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
3 - 5 Months	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
6 - 11 Months	98,520	18.0%	30,276	13.0%	109,245	17.6%	31,161	13.5%	83,705	17.6%	21,935	14.2%
12 - 23 Months	141,229	17.3%	44,073	13.3%	165,934	17.1%	48,630	13.4%	130,188	16.9%	35,111	13.9%
24 - 35 Months	96,911	19.4%	30,467	15.9%	110,742	18.2%	32,255	15.7%	86,847	17.3%	23,340	15.8%
35 - 59 Months	206,059	15.3%	65,630	11.5%	233,357	14.4%	69,286	11.0%	188,311	13.8%	50,756	11.3%
Total	542,719	70.0%	170,446	53.7%	619,278	67.3%	181,332	53.6%	489,051	65.6%	131,142	55.2%

Source: Pediatric Nutrition Surveillance.

Appendix H – Detailed Adult Literacy Tables

Live Births by Mother's Education, Shasta County, 1997-1999

Shasta County	1997		1998		1999	
Mother's Education in Years Completed	Number of People	Percent of Total	Number of People	Percent of Total	Number of People	Percent of Total
None	2	0.1%	1	0.1%	3	0.2%
1-3 Years	6	0.3%	5	0.3%	4	0.2%
4-6 Years	16	0.8%	10	0.5%	15	0.8%
7-9 Years	94	4.7%	68	3.5%	56	3.0%
10-11 Years	335	16.8%	338	17.4%	293	15.9%
12 Years	758	37.9%	736	37.9%	691	37.5%
13-15 Years	517	25.9%	515	26.5%	534	28.9%
16 Years and Over	259	13.0%	264	13.6%	238	12.9%
Unknown	13	0.7%	6	0.3%	11	0.6%
Total Number of Births	2,000	100%	1,943	100%	1,845	100%

Source: State of California, Department of Health Services, Birth Records.

Live Births by Father's Education, Shasta County, 1997-1999

Shasta County	1997		1998		1999	
Father's Education in Years Completed	Number of People	Percent of Total	Number of People	Percent of Total	Number of People	Percent of Total
None	5	0.3%	6	0.3%	6	0.3%
1-3 Years	7	0.4%	1	0.1%	3	0.2%
4-6 Years	19	1.0%	10	0.5%	22	1.2%
7-9 Years	40	2.0%	49	2.5%	38	2.1%
10-11 Years	245	12.3%	243	12.5%	184	10.0%
12 Years	765	38.3%	747	38.4%	698	37.8%
13-15 Years	452	22.6%	426	21.9%	450	24.4%
16 Years and Over	275	13.8%	279	14.4%	268	14.5%
Unknown	192	9.6%	182	9.4%	176	9.5%
Total Number of Births	2,000	100%	1,943	100%	1,845	100%

Source: State of California, Department of Health Services, Birth Records.

Live Births by Mother's Education, California, 1997-1999

California	1997		1998		1999	
Mother's Education in Years Completed	Number of People	Percent of Total	Number of People	Percent of Total	Number of People	Percent of Total
None	2,958	0.6%	2,376	0.5%	2,248	0.4%
1-3 Years	8,537	1.6%	7,673	1.5%	7,225	1.4%
4-6 Years	42,295	8.1%	39,244	7.5%	38,517	7.4%
7-9 Years	50,014	9.5%	47,309	9.1%	47,348	9.1%
10-11 Years	62,721	12.0%	62,232	11.9%	59,734	11.5%
12 Years	151,083	28.8%	150,679	28.9%	149,261	28.8%
13-15 Years	102,324	19.5%	102,416	19.6%	101,670	19.6%
16 Years and Over	97,051	18.5%	100,260	19.2%	104,331	20.1%
Unknown	7,191	1.4%	9,076	1.7%	7,739	1.5%
Total Number of Births	524,174	100%	521,265	100%	518,073	100%

Source: State of California, Department of Health Services, Birth Records.

Live Births by Father's Education, California, 1997-1999

California	1997		1998		1999	
Father's Education in Years Completed	Number of People	Percent of Total	Number of People	Percent of Total	Number of People	Percent of Total
None	2,909	0.6%	2,300	0.4%	2,460	0.5%
1-3 Years	8,263	1.6%	7,321	1.4%	7,060	1.4%
4-6 Years	39,974	7.6%	37,903	7.3%	37,306	7.2%
7-9 Years	40,706	7.8%	39,289	7.5%	40,019	7.7%
10-11 Years	44,116	8.4%	44,246	8.5%	42,566	8.2%
12 Years	148,470	28.3%	148,089	28.4%	147,729	28.5%
13-15 Years	86,289	16.5%	86,188	16.5%	85,488	16.5%
16 Years and Over	104,567	19.9%	106,690	20.5%	108,855	21.0%
Unknown	48,880	9.3%	49,239	9.4%	46,590	9.0%
Total Number of Births	524,174	100%	521,265	100%	518,073	100%

Source: State of California, Department of Health Services, Birth Records.

Appendix I – List of Indicators for Which Data Were Not Found

The number of eligible children and pregnant women enrolled in Healthy Families, Medi-Cal, AIM and / or other programs available for health coverage (found Medi-Cal data only)
The number of families accessing early care and education through a coordinated, centralized service
The number of CPS reports that are repeat referrals
The number of domestic violence reports involving young children
The number of infants whose mothers used drugs during their pregnancy
The number of women who initiated breastfeeding
The number of women who breastfed their infants until 6 months of age
The number of women who breastfed their infants until 1 year of age
The number of free or reduced -price entrance fees to cultural arts programs
The number and diversity of ECE college courses and programs available in Shasta County
Dental caries and diseases for children entering kindergarten
Number of children receiving early dental services (California data only)
The number of four year old children eligible for Head Start who are enrolled in Head Start
The average number of years of experience working in early care and education per provider
The number of caregivers who leave the early care and education profession in a 12-month period
The number of all infants exposed to tobacco during pregnancy
The number of smoking or substance abusing women / primary caregivers accessing cessation, substance / alcohol abuse treatment services
The percentage of children ages 0-to-5 who are overweight
The number of community offerings of affordable and accessible activities that promote physical activity for families with young children
The number of booster swings and other equipment suitable for toddlers available in parks and recreational facilities
The number of well-child exams per child before the age of 2 years old
The number of unlicensed providers who become licensed (California data only)
The number of domestic violence reports involving young children zero to five years of age
The number of children ages 0-to-5 who are exposed to second-hand smoke in their homes
The number of caregivers who have had their jobs for more than 12 months
The number of parks, gyms and other health enhancing recreational spaces and programs
The number of parks and public spaces available for family activities

Glossary

— A —

— B —

Breastfeeding initiation: If in the absence of unusual circumstances, a mother attempts to breastfeed her infant within the first 24 hours after delivery, breastfeeding is defined as being initiated.

— C —

Child abuse and neglect is physical injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child by a person who is responsible for the child's welfare, under circumstances, that indicate the child's health or welfare is harmed or threatened.

Child care centers normally operate outside of the licensees' homes and provide non-medical care and supervision to infants, toddlers, preschoolers, and/or school-age children for periods of less than 24 hours. These centers are usually in commercial buildings.

Child care for children with special developmental needs meets the following criteria:

- For family child care home, providers shall possess a valid family child care license issued by the Department of Social Services (DSS) or by an agency authorized by DSS to assume specified licensing responsibilities. Under regulations, such facilities will provide non-medical care and supervision to children under 18 years of age on a less than 24-hour basis per day.
- For a child care center caring for children with special developmental needs, providers shall possess a preschool license issued by the Department of Education or a valid child care center license issued by DSS or an agency authorized by DSS to assume specified licensing responsibilities. Child care centers aid in developing pre-academic skills, group training, and social skills in a nonresidential facility that provides personal care, protection, and supervision for children less than 18 years of age with special developmental needs.

— D —

Developmental disabilities are a heterogeneous group of physical, cognitive, psychological, sensory, and speech impairments that arise during development from birth to 18 years old.

Domestic violence is an escalating pattern of abuse where one or both partners in an intimate relationship controls the other through force, intimidation, or the threat of violence. Abuse comes in many forms, including physical, sexual, emotional, verbal, and psychological.

— E —

Early prenatal care is at least one prenatal care visit during the first trimester of pregnancy.

— F —

Family child care homes operate in licensees' own homes and provide non-medical care and supervision in a homelike environment for less than a 24-hour period. Family child cares homes can be licensed for 6 or fewer children or 12 or fewer children. Homes are regulated by Community Care Licensing, which inspects areas such as health and safety, adult-child ratio, caregiver training, equipment, nutrition, and behavior and guidance.

— H —

Head Start is a national program that provides comprehensive developmental services for low-income children. Head Start provides educational, social, medical, dental, nutrition, mental health services, and parent involvement activities.

— I —

— J —

— K —

— L —

Late prenatal care is defined as prenatal care that begins after the first trimester (the first 3 months) of pregnancy. Receiving prenatal care late in pregnancy, or receiving no prenatal care at all, can lead to negative health outcomes for mother and child. Women who receive care late in pregnancy or who do not receive care at all are at an increased risk of bearing infants with a low birth weight, who are stillborn, or who die within the first year of life.

Licensed child care center. To start a licensed child care center, an applicant must:

- Be at least 18 years of age.
- Attend a series of licensing orientations.
- Verify that the directors and teachers have at least 12 units in early childhood education. Directors must also have at least three units in administration or staff relations.
- Must be fingerprinted and undergo a Child Abuse Index Check. This also includes all staff. Everyone working in the home must also sign a statement, under penalty of perjury, that she or he has never been convicted of a crime other that a minor traffic violation.
- Pass a fire inspection.

Licensed family child care homes ensure minimum standards for the care and protection of children. Community Care Licensing checks such areas as health and safety, adult-child ratio, caregiver training, equipment, nutrition, and behavior and guidance. Only licensed family child care homes can participate in the Child and Adult Food Program. Only licensed family child care homes can receive payments from the Department of Human Services.

Licensing is aimed to address the health and safety of the children in care.
License exempt - If an adult cares for children from only one family (in addition to his or her own), that individual is not required to have a license and considered to be license exempt. There are 5 criteria for exemption from licensing:

- Relatives – related by blood, marriage or adoption.
- Parents on site (Health Club, PEN Family Center, stores like Fred Meyer, etc.).
- On school site and/or recreation programs running 1 to 6 week sessions.
- Co-Op – trading child care with another family and no money exchanges hands.
- Caring for the children of one other family only.

— M —

Medi-Cal - The Medi-Cal Program provides access to health care services for people whose assets and income are insufficient to pay medical bills and meet basic monthly needs. Individuals already receiving cash assistance through CalWORKs and SSI/SSP are automatically eligible for

Medi-Cal. Medi-Cal is a federally and state-funded health insurance program for people who are low-income, elderly, disabled, or enrolled in TANF.

For the elderly and disabled, Medi-Cal can pay for hospital and doctor's bills, prescription drugs, medical equipment and supplies, home health assistance, nursing home care, adult care, medically related transportation, and many other services or items. It usually pays 100% of the cost of services, however, some services may sometimes require a very small co-payment from the recipient.

Families who are not recipients of cash aid, but whose resources are within the Medi-Cal limits, may receive benefits. Some have to pay a monthly share of cost before Medi-Cal benefits become effective.

Mental emotional abuse can be defined as, but not limited to, any one of the following situations: blaming, belittling or rejecting of a child; consistently treating siblings unequally in a family environment; and a persistent lack of concern by the caretaker for the child's welfare.

Mental disability includes, but is not limited to, all of the following:

- Having any mental or psychological disorder or condition, such as mental retardation, organic brain syndrome, emotional or mental illness, or specific learning disabilities, which limit a major life activity.
- Having any other mental or psychological disorder or condition not described above that requires special education or related services.
- Having had any mental condition that makes achievement of a major life activity difficult.

Morbidity and Mortality – Morbidity is defined infant illness and mortality is defined as death.

— N —

Neglect is the inability or unwillingness of a parent, guardian, or custodian of a child to provide the child with supervision, food, clothing, shelter, or medical care causing substantial risk or harm to the child's health or welfare. Child neglect may be waived if it is determined the ability of a parent, guardian, or custodian to meet the needs of a child is impaired with a disability or chronic illness.

No prenatal care is defined as no visits to a hospital, clinic, or any other pregnancy-related care prior to the delivery of the child.

— O —

— P —

Physical abuse is the impairment of physical condition that includes but shall not be limited to any skin bruising, pressure sores, bleeding, failure to thrive, malnutrition, dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ, or any physical condition that imperils health or welfare.

Prenatal care is health care and other services available to pregnant women as a fetus develops. Potential mothers, before and during pregnancy, may use services to promote positive lifestyle

behaviors including risk-specific referrals and obstetrical care until the onset of labor and delivery of a newborn infant. The purpose of prenatal care is to decrease the number of infants born too soon (pre-term birth), too small (low birth weight), and to prevent mother and infant sickness and death. Adequate prenatal care usually begins in the first three months of pregnancy and lasts until birth.

— R —

— S —

Special health care needs refers to the special needs of a child with a developmental disability.

Sexual abuse is the involvement of a dependent child (under 18 years of age), developmentally immature child, or adolescent in sexual activities that the child does not fully comprehend; is unable to give informed consent to; or violates the social taboos of family roles.